



Municipal Insurance Enrollment and Change Form (FORM -1MUN)

01 <input type="checkbox"/>		Insured's GIC-ID (usually Soc. Sec. #) ____		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>		Date of Birth ____/____/____		Dept. ID # or Agency/Division # 666/																					
Name - Last ____						First ____		MI ____		Check one: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> Survivor																			
Address ____						<input type="checkbox"/> This is a new address		City ____		State ____																			
Date Entered Service ____/____/____		City or Town employed or retired from ____				Home Phone (____) ____-____		Work Phone (____) ____-____																					
02 <input type="checkbox"/>										HEALTH COVERAGE		Effective Date: ____/____/____																	
New Enrollment <input type="checkbox"/>		Change <input type="checkbox"/>		Cancel Coverage <input type="checkbox"/>																									
<input type="checkbox"/> Health (Select one of the health plans below and individual or family coverage)																													
<div>Health Plan – Active Employees and Non-Medicare Retirees/Survivors</div> <table border="1"><tr><td><input type="checkbox"/> Fallon Direct (HMO)</td><td><input type="checkbox"/> NHP Care – Neighborhood Health Plan (HMO)</td><td><input type="checkbox"/> UniCare State Indemnity/Basic CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No</td><td rowspan="5"><u>Coverage</u> <input type="checkbox"/> Individual <input type="checkbox"/> Family</td></tr><tr><td><input type="checkbox"/> Fallon Select (HMO)</td><td><input type="checkbox"/> Tufts Health Plan Navigator (PPO)</td><td><input type="checkbox"/> UniCare/Community Choice (PPO-type)</td></tr><tr><td><input type="checkbox"/> Harvard Pilgrim Independence (PPO)</td><td><input type="checkbox"/> Tufts Health Plan Spirit (HMO-type)</td><td><input type="checkbox"/> UniCare/PLUS (PPO-type)</td></tr><tr><td><input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO)</td><td></td><td></td></tr><tr><td><input type="checkbox"/> Health New England (HMO)</td><td></td><td></td></tr></table>														<input type="checkbox"/> Fallon Direct (HMO)	<input type="checkbox"/> NHP Care – Neighborhood Health Plan (HMO)	<input type="checkbox"/> UniCare State Indemnity/Basic CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Coverage</u> <input type="checkbox"/> Individual <input type="checkbox"/> Family	<input type="checkbox"/> Fallon Select (HMO)	<input type="checkbox"/> Tufts Health Plan Navigator (PPO)	<input type="checkbox"/> UniCare/Community Choice (PPO-type)	<input type="checkbox"/> Harvard Pilgrim Independence (PPO)	<input type="checkbox"/> Tufts Health Plan Spirit (HMO-type)	<input type="checkbox"/> UniCare/PLUS (PPO-type)	<input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO)			<input type="checkbox"/> Health New England (HMO)		
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03 <input type="checkbox"/> Name Change		Previous Name ____						New Name ____																					
INSURED CHANGES										FOR GIC USE ONLY:		Effective Date: ____/____/____																	
06 <input type="checkbox"/> Retirement		Date Retired ____/____/____																											
07 <input type="checkbox"/> Transfer to another Agency/Municipality		Name of Agency/Municipality Transferred to ____						Effective Date ____/____/____																					
08 <input type="checkbox"/> Transfer from another Agency/Municipality		Previous Agency/Municipality ____						Effective Date ____/____/____																					
09 <input type="checkbox"/> Termination Coverage (if elected)		Termination Reason ____																											
Termination Date ____/____/____																													
<input type="checkbox"/> 39-Week Layoff Coverage <input type="checkbox"/> Deferred Retiree <input type="checkbox"/> COBRA (must complete COBRA application) <input type="checkbox"/> Conversion (contact carrier for application)																													
School Department Employees Only: Termination date ____/____/____ Premiums paid through ____/____/____																													
SIGNATURE REQUIRED	Deduction Authorization I authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected.																												
	Health Insurance: I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan.																												
	At Retirement I hereby certify that I have filed an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage.																												
	Survivors I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage.																												
	Termination I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.																												
	<div>• If you are applying for Health Insurance, be sure to file a Form IDF to list family members.</div>																												
x _____		Date _____		x _____		Date _____																							
Signature of Applicant		Date		Signature of Authorized Official		Date																							
FOR GIC USE ONLY:		Entered		Verified		Political Subdivision																							